08/14/2	1017 HON 11:53 1	FAX 8655942168 Dept of He	alth.		∑ 10	17/026
DED407	SACKE ACUTALITY	AND HUMAN SERVICES	Ы	f the form	PRINTED: (
			JP9/16	117 1·70 × 14 1 1 1/7 .		PPROVED
				· [1] : [<u>OMB NO. (</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LE DONSTRUCTION	(X3) DATE	SURVEY LETED
איינט ן עאיינע	. 00/11/20/10/1		A. BUILDING	G 01 - BUILDING A	00	
		445131	B. WING_		07/3	1/2017
NAME OF E	PROVIUER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0119	1720,17
				5321 BEYERLY PARK CIRCLE		
8EVERU	Y PARK PLACE HEAL	TH AND REHAB		KNOXVILLE, TN 37918		
[X4] ID		TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECT!	ON	(AS) COMPLETION
PREFIX .		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		DATE
TAG	(CLOCK) OR LOCK	SCIOCALL FIRS INFORMATION	ino	DEFICIENCY)	TAPATA	
	<u>• · · · · · · · · · · · · · · · · · · ·</u>			· · · · · · · · · · · · · · · · · · ·		
K 000	INITIAL COMMENT	rs	K 004	0 K-111		
				K-111		_
	A life safety survey	was conducted by the state of		1.	X	1-cd-17
		nent of Health, Division of		On 08-02-17, Merit Construction Co	omany wak	•
		d regulation office of health	İ	notified by the Maintenance Director of the need to		
		31/17. During this life safety	i	repair the fire doors on the second and third floors		
	survey, Beverly Par	k Place Health and	-	in the area of the new construction and the unscaled		
		not found to be in substantial		penetrations on the third floor in the	area of the	
	compliance with the requirements for participation			new construction. The repairs will	be complete	ď
		aid at 42 CFR Subpart		by Merit Construction by 09-01-17.		
		ety from fire, and the related		<u>2.</u>	i i	
		ction Association (NFPA)		The Maintenance Director conducted	d a 1,0094 a b	
	standard 101 - 201	z eamon.		of fire doors and fire walls on 08-01-	-17 No oth	OIL 65
	The requirement of	42 CFR, Subpart 483,70(a) is		areas were identified as being affecte	ari.	Li
	NOT MET as evide				·]	
K 111	NFPA 101 Building		K 11	<u> 3.</u>	,	
SS=D	Milita Io. Daliand	11et admitaboti	"	The Maintenance Director in-service	d the	
2240	Building Rehabilitat	ion.		maintenance staff on 08-14-17 on pro-	oper fire dec	or
	Repair, Renovation	, Modification, or		gaps and wall penetrations and to che	eck outside	
i	Reconstruction	•		vendors for proper work performed.		
	Any building underg	going repair, renovation,		4.	į	
Ì		onstruction complies with both	ļ	A 100% audit will be completed mor	i bee Sy vidte	lor.
	of the following:			until 100% compliance by the Mainte	enance	
	* Requirements of (Director of fire doors and fire walls f	or proper ga	DS
		the applicable Sections 43.3, i		and penetrations.	· · ·]	•
	43.4, 43.5, and 43.6					
	18.1.1.4.3, 19.1.1.4	Dhange of Occupancy		Results of the findings will be reported	ed to the	
		going change of use or change		Quality Assurance Performance Impr	ovement	•
		ification complies with the	ĺ	Committee x 3 months or until 100%	compliande	is
		ction 43.7, unless permitted by		achieved. The Quality Assurance Per Improvement Committee consists of	riormance	
	18.1.1.4.2 or 19.1.1			Administrator, Director of Nursing, A	lile Legistant	
		id 4.6.11), 19.1.1.4.2 (4.6.7		Director of Nursing, Unit Managers,	Therany	
	and 4.6.11), 43.1.2.			Manager, Staff Development Coording	nator, Social	
	Additions	· · · · · · · · · · · · · · · · · · ·	}	Services Department, MDS Coordina	itors,	
		joing an addition shall compty		Maintenance Director, Laundry Direct	tor,	
		nts of Section 43.8. If the		Admissions Director, Business Office	: Manager,	
	building has a com-	mon wall with a nonconforming		Housekeeping Director, Medical Reco	ords, Dietaly	/
			<u> </u>	Manager, Activity Director, and Med		
ABORATORY L	DIRECTOR'S OR PROVID	URVSUPPLIER REPRESENTATIVE'S SIGN	NATURE,	TITLE	,() 	ION CATE

Susete Willeamben

Any deficiency statement ending with an asterisk (") denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegueros provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whicher or not a plan of correction is provided. For nursing homes, the above lindings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requestly to continued program participation.

FORM CMS-2667(07-99) Pravious Versions Chapters

Event ID: QVZY21

Facility ID: TN4705

If continuation sheet Page 1 of 9

W018/026

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 09/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - BUILDING A		(X3) DATE SURVEY COMPLETED			
			B. WING				07/74/2047		
ł	PROVIDER DR SUPPLIER Y PARK PLACE HEA!	LTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 6321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918			1 02	07/31/2017		
(X4) ID PREFOI TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		4	PROVIDER'S PLAN OF CORRESPICATION OF CORRESPICATION OF CORRESPICATION OF CROSS-REFERENCED TO THE APPLICATION OF CORRESPOND OF CORRESPOND OF CROSS-REFERENCED TO THE APPLICATION OF CORRESPICATION OF CORRESPOND OF CO			(X5) COMPLETION DATE		
PRÉFOI (EACH DÉFICIENCY MUST DE PRECEDE		on wall is a fire barrier having a resistance rating constructed uired for the addition. enings occur only in corridors by approved self-closing fire a 1-1/2-hour fire resistance imply with the requirements of ad 4.5.11), 18.1.1.4.1.1 (8.3), 4.1.3, 19.1.1.4.1.2, 3(43.8) is not met as evidenced by: ion, the facility falled to and fire barrier walls in the 2 separation of a ding. 19.1.3.5, 8.3.3.1 (3.3.1.7.1) cits 2 of 19 smoke 2: 1/17 between 2:50 PM and the following: a 2 hour fire barrier have a inch at the meeting edges of d and 3rd floor connector of ouilding, rations in the 2 hour fire bar connector of the ling.	K	11			COMPLETION		
į,	was identified and a	esent when the deficiency cknawledged by the the exit conference on				! ! !			

08/14/2017 HON 11:53 FAX 8655942168 Dept of Health

2019/026

PRINTED: 08/03/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING O1 - BUILDING A 445131 07/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5321 BEVERLY PARK CIRCLE SEVERLY PARK PLACE KEALTH AND REHAB KNOXVILLE, TN 37918 SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (X4) ID (NS) COMPLETION (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG TAG DEFICIENCY) K 111 Continued From page 2 K 111 7/31/17. K-200 9-01-17 K 200 NFPA 101 Means of Egress Requirements -K 200 SS≃F Proper signage was posted on the cross corridor Means of Egress Requirements - Other doors on the first, second and third floors on 08-03-List in the REMARKS section any LSC Section 17 by the Maintenance Director. The Main floor 18.2 and 19.2 Means of Egress requirements that does not require signage as the cross corridor door are not addressed by the provided K-tags, but are does lead to an exit. deficient. This information, along with the applicable Life Safety Code or NFPA standard The Maintenance Director conducted a 100% audit citation, should be included on Form CMS-2567. on 08-01-17 for proper signage on doors. No other 18.2, 19.2 areas were identified as being affected. The Maintenance Director in-serviced the maintenance staff on 08-14-17 on signage This STANDARD is not met as evidenced by: placement and proper wording. Based on observation the facility failed to identify doors that are likely to be mistaken for an exit with No Exit signage. Proper signage on doors will be audited monthly x3 and/or until 100% compliance by the Maintenance NFPA 101 2012 Ed. 19.3.7.5.1, 7.10.8.3.1 Director. This deliclency affects 4 of 19 smoke Results of the findings will be reported to the compartments Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is The findings include: achieved. The Quality Assurance Performance Improvement Committee consists of the Observation on 7/31/17 at 3:40 PM revealed Administrator, Director of Nursing, Assistant cross corridor doors leading into the crosswalk Director of Nursing, Unit Managers, Therapy connectors on the main tavel, 1st, 2nd, and 3rd Manager, Staff Development Coordinator, Social floor are not the means of egress for the nursing Services Department, MDS Coordinators, home and can be mistaken for an exit. These Maintenance Director, Laundry Director. doors are not identified by a NO Exit sign. Admissions Director, Business Office Manager Housekeeping Director, Medical Records, Dietery Maintenance was present when the deficiency Manager, Activity Director, and Medical Director was identified and acknowledged by the

FORM CMS-2587(02-99) Pravious Versions Obsolete

administrator during the exit-conference on

Event ID: QVZY21

Facility ID. TN4705

If continuation sheet Page 3 of 9

08/14/2017 NON 11:54 FAX 8655942168 Dept of Health

Ø020/026

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/03/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING D1 - BUILDING A COMPLETED 445131 B. WING 07/31/2017 NAME OF PROVIDER OR SUPPLIER STREET AODRESS, CITY, STATE, ZIP CODE 5321 BEVERLY PARK CIRCLE BEVERLY PARK PLACE HEALTH AND REHAB KNOXVILLE, TN 37918 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD RECROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG IAG MALE DEFICIENCY) K 200 | Continued From page 3 K 200 7/31/17. K-321 NFPA 101 Hazardous Areas - Enclosure K 321 K 321 SSME The holes in the wall in the laundry chute collection Hazardous Areas - Enclosure room were repaired from 08-03-17 to 08-04-17 by 2012 EXISTING maintenance staff. The repairs on the unsealed Hazardous areas are protected by a fire barrier penetrations and "blow out patch" in the lower having 1-hour fire resistance rating (with 3/4-hour level mechanical room were initiated by fire rated doors) or an automatic fire extinguishing maintenance staff on 08-15-17 and will be system in accordance with 8.7.1. When the completed by 08-25-17. The repairs on the head of approved automatic fire extinguishing system the wall, unsealed penetrations and "blow out option is used, the areas shall be separated from patch" in the third floor mechanical room were other spaces by smoke resisting partitions and initiated by maintenance staff on 08-15-17 and will doors in accordance with 8.4. Doors shall be be completed by 08-25-17. self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of The Maintenance Director conducted a 100% midit the door. of the laundry room and all mechanical rooms for Describe the floor and zone locations of wall repair and penetrations. No other areas were hazardous areas that are deficient in REMARKS. identified as being affected. 19.3.2.1 Агеа Automatic Sprinkler The Maintenance Director in-serviced the Separation N/A maintenance staff on wall penetrations and repair a. Boller and Fuel-Fired Heater Rooms on 08-14-17. b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d, Spilled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hezerd - see K322) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas - enclosures. This deficiency affected 3 of 19 smoke compartments.

08/14/2017 NON 11:54 FAX 8655942168 Dept of Health

Ø021/026

PRINTED: 08/03/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATC SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 61 - BUILDING A 445131 07/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5321 BEVERLY PARK CIRCLE BEVERLY PARK PLACE HEALTH AND REHAB KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY** K 321 Continued From page 4 K 321 9-01-17 The Maintenance Director will conduct an audit of NFPA 101, 19.7.6 the laundry and mechanical rooms for wall NFPA 101, 19.3.2.1 penetrations and repair monthly x3 and/or until 100% compliance, The findings include: Results of the findings will be reported to the Quality Assurance Performance Improvement Based on observation and interview, the facility Committee x 3 months or until 100% compliance is failed to maintain hazardous areas - enclosures in achieved. The Quality Assurance Performance the following locations; Improvement Committee consists of the Administrator, Director of Nursing, Assistant Lower level mechanical equipment room had Director of Nursing, Unit Managers, Therapy multiple unsealed penetrations and an Manager, Staff Development Coordinator, Social unapproved "blow out patch." Services Department, MDS Coordinators, The lower level faundry chute collection room Maintenance Director, Laundry Director, had several holes in the walls. Admissions Director, Business Office Manager Third floor mechanical room head of wall was Housekeeping Director, Medical Records, Dietary unsealed, unsealed penetrations and an Manager, Activity Director, and Medical Director unapproved "blow out patch." The maintenance director was present when the deficiencies were identified and was acknowledged by the administrator during the exit conference on 7/31/17. NFPA 101 Subdivision of Building Spaces -K 372 K 372 SS=E | Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction

FORM CMS-2507(02-99) Viewinus Versions Obsolete

2012 EXISTING

Smoke barriers shall be constructed to a 1/2-hour tire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct

penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke

Event ID: OVZY21

Feating ID: TN4705

If continuation sheet Page 5 of 9

0E/14/2017 MON 11:54 FAX 8655942168 Dept of Health

Ø022/026

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CONFECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - BUILDING A	(X3) DAT	(X3) DATE SURVEY COMPLETED	
	445131		B. WING	***************************************	07/3	07/31/2017	
NAME OF PROVIDER OR SUPPLIER BEVERLY PARK PLACE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918				
IX4) ID PREFIX TAG	[(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION GROSS REFERENCED TO THE DEFICIENCY)	SHOULD DE	GOMPLETION DATE	
K 372	Continued From page 5 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barrier walls. NFPA 101 2012 Ed. 19.3.7.3 This deficiency affects 3 of 19 smoke compartments.		K 3	K-372 L On 08-07-17, contact was ma Maintenance Director to the 3 representative to obtain infort fire caulk system to utilize. The emailed to the Maintenance Expresentative on 08-11-17. Director ordered the fire caull repairs to the smoke walls with maintenance staff by 09-01-1	M-fire caulk mation on the con the information when the information when the information with the Maintenance k on 08-17-17. The becompleted by	as	
	3:30 PM revealed in the following lot 1. Above ceiling barrier wall has 1 head wall is not so 2. Inside room 3 have approved fir caulking. 3. Above ceiling unsealed penotral	(31/17 between 3:00 PM and penetrations in smoke barriers sations; by room 301 in corridor, smoke unsealed penetration and the		2. The Maintenance Director corof smoke walls on 08-03-17. identified as being affected. 3. The Maintenance Director inmaintenance staff on different and their uses on 08-14-17. 4. The Maintenance Director will ensure no wall penetrations ar x3 and/or until 100% compliants.	No other areas we serviced the fire caulk system I conduct an audie unsealed month	ere s	
K 374 SS=E	Maintenance was was identified and administrator duri 7/31/17, NFPA 101 Subdivi Smoke Barrie	present when the deficiency acknowledged by the acknowledged by the graph of the exit conference on a sion of Building Spaces - acknowledged Spaces - Smoke Barrier	К 37	Results of the findings will be Quality Assurance Performanc Committee x 3 months or unti- achieved. The Quality Assura Improvement Committee cons Administrator, Director of Nur Director of Nursing, Unit Man Manager, Staff Development (Services Department, MDS Committee Director, Laundr Admissions Director, Business Housekeeping Director Medic	ce Improvement 1 100% compliant nce Performance sists of the rsing, Assistant lagers, Therapy Coordinator, Social cordinators, y Director, s Office Manager	u .	

08/14/2017 MON L1:55 FAX 8655942168 Dept of Health

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

2023/026 PRINTED: 08/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORFECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - BUILDING A			(X3) DATE SURVEY COMPLETED	
		445151	B. WING	·		07/	31/2017
	PROVIDER OR SUPPLIER Y PARK PLACE HEA			633	REET ADDRESS, CITY, STATE, ZIP CODE 21 BEVERLY PARK CIRCLE NOXVILLE, TN 37918		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FILL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTS (LACIA CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRICIENCY)	DBE	(×5) COMPLETION DAFE
K 923 SS-E	bonded wood-core resists fire for 20 m plates of unlimited are permitted to ha assemblies per 8.5 automatic-closing, are not required to egress travel. Door clear width of 32 in doors. 19.3.7.6, 19.3.7.8, This STANDARD is Based on observamintain smoke bandlain smoke bandlain smoke bandlain smoke bandlain smoke band room 201 failed the passage of smoke the passage	rriers are 1-3/4-inch thick solid doors or of construction that sinutes. Nonraled protective height are permitted. Doors we fixed fire window. Doors are self-closing or do not require latching, and swing in the direction of opening provides a minimum ches for swinging or horizontal 19.3.7.9 is not met as evidenced by: Ition, the facility failed to order doors. 1. 19.3.7.6, 19.3.7.6, 19.3.7.9 acts 4 of 19 smoke e: 1.1/17 at 11:35 AM and 2:15 PM order doors in front of room 301 d to close completely to resist oke.		923	L. The fire doors outside of rooms 201 repaired and tested on 08-01-17 by r staff. 2. The Maintenance Director conducted of fire doors on 08-01-17. No other identified as being affected. 3. The Maintenance Director in-service maintenance staff on fire door operator. 4. The fire doors will be audited for propand closure by the Maintenance Director and closure by the Maintenance Imp. Committee x 3 months or until 100% achieved. The Quality Assurance Pelmprovement Committee consists of Administrator, Director of Nursing, Administrator, Director of Nursing, Unit Managers, Manager, Staff Development Coordinance Services Department, MDS Coordinance Maintenance Director, Laundry Director Admissions Director, Business Office Housekeeping Director, Medical Rec Manager, Activity Director, and Medical Recommits of the staff of th	a 100% a areas were d the tions on 08 aper operator montification to the accompliant reformance the assistant Therapy maters, soior, a Manager ords, Diet	udit

08/14/2017 HON 11:55 FAX 8655942168 Dept of Health

Ø024/026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
GENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (XI) PROVINER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l ' '	ETIPLE CONSTRUCTION DING 01 - BUILDING A		(X3) DATE SURVEY COMPLETED	
		445131	B. WING)	07	1/31/2017	
NAME OF PROVIDER OR SUPPLIER BEVERLY PARK PLACE HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ANDRESS, CITY, STATE, ZIP CODE 5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918 ID MROVIDER'S PLAN OF CORRECTION				
PRÉFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI		E APPROPRIATE	COMPLETION DATE	
K 923	5.1.3.3.3. >300 but <3,000 Storage tocations within an enclose limited- combusti gates outdoors) it gases are not sto separated from cosprinklered) or encormbustible of 1/2 hr. fire protect Less than or equal na single smoke cylinders available care areas with a or equal to 300 ctored in an enclohandled with precautionary seach door or gate where the sign in minimum "CAUTI STORED WITHISTORED WITHIS	cubic feet are outdoors in an enclosure or d interior space of non- or ble construction, with door (or hat can be secured. Oxidizing wed with flammables, and are combustibles by 20 feet (5 feet if aclosed in a cabinet of construction having a minimum tion rating. at to 300 cubic feet compartment, individual e for immediate use in patient in aggregate volume of less than ubic feet are not required to be exautions as specified in 11.6,2. sign readable from 5 feet is on e of a cylinder storage room, cludes the wording as a ION: OXIDIZING GAS(ES) IN OSMOKING." et dso cylinders are used in order received from the supplier. are segregated from full facility employs cylinders with gauge, a threshold pressure of is established. Empty cylinders and confusion. Cylinders stored rotected from weather. 3.3, 11.3.4, 11.6.5 (NFPA 99) is not met as evidenced by: ration and interview, the facility oxygen storage areas. This d 2 of 19 smoke compartments.	KS	K-923 L. Signage was ordered on 08-08-07-17 by the Maintenance and Lower Level oxygen stores for signage on oxygen stores No other areas were identified. The Maintenance Director is maintenance staff on signage wording on 08-14-17. L. Oxygen storage rooms will and/or until 100% compliant Director for proper signage.	ce Director on the prage rooms. conducted a 100% ge rooms on 08-ted as being affect as being affect as prize the e placement and the be audited month.	6 audit 07-17. ted. proper	

FORM CMS-2967(02-99) Provious Versions Obsolute

08/14/2017 HON 11:55 FAX 8655942168 Dept of Health

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ø025/026

PRINTED: 08/03/2017 FORM APPROVED

If continuation sheet Page 9 of 9

CENTERS FOR MEDICARE & MEDICAID SERVICES							. 0938-0391	
STATEMENT OF DEFICIENCIES () AND PLAN DE CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	1 -	MULTIPLE CONSTRUCTION UILDING 01 - BUILDING A			E SURVEY	
		445131	B. WING			07/	31/2017	
	PROVIDER OR SUPPLIER Y PARK PLACE HEAL	TH AND REHAB	STREET ADDRESS, CITY. STATE, ZIP CODE 5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918					
(X4) ID PREFIX TAG	(EACH DEI*ICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION SHOUL (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROVIDER (EACH)	o 0.E	COMPLETION COMPLETION	
K 923	director on 7/31/17 revealed the main of oxygen storage on the provided with requirements the maintenance dideficiencies were id.	erview with the maintenance between 11:00 and 11:46 AM exygen storage room and the ground floor were not ed signage. Irector was present when the entified and was a game and the exit.	KS	323		rovement formance the Assistant Therapy nator, Socators, etor, e Manage cords, Die	ice is	
						ļ		

Event ID: QVZY21

Facility ID. TN4705